



Springboro Community City Schools Health Services  
**SEIZURE ACTION PLAN**

Insert  
Student  
Photo Here

HS 748-3950    JH 748-3953    SI 748-4113    DE 748-6070    FP 748-6090    CE 748-3958

Effective Date \_\_\_\_\_

THIS STUDENT IS BEING TREATED FOR A SEIZURE DISORDER. THE INFORMATION BELOW SHOULD ASSIST YOU IF A SEIZURE OCCURS DURING SCHOOL HOURS.

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Bus#: \_\_\_\_\_  
 Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_  
 Treating Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Significant medical history: \_\_\_\_\_

**SEIZURE INFORMATION:**

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs: \_\_\_\_\_

Student's reaction to seizure: \_\_\_\_\_

**BASIC FIRST AID: CARE & COMFORT:**

*(Please describe basic first aid procedures)*

Does student need to leave the classroom after a seizure? YES NO  
 If YES, describe process for returning student to classroom \_\_\_\_\_

**EMERGENCY RESPONSE:**

A "seizure emergency" for this student is defined as: \_\_\_\_\_  
 \_\_\_\_\_

**Basic Seizure First Aid:**

- ✓ Stay calm & track time
- ✓ Keep child safe
- ✓ Do not restrain
- ✓ Do not put anything in mouth
- ✓ Stay with child until fully conscious
- ✓ Record seizure in log

For tonic-clonic (grand mal) seizure:

- ✓ Protect head
- ✓ Keep airway open/watch breathing
- ✓ Turn child on side

Seizure Emergency Protocol: *(Check all that apply and clarify below)*

- Contact school nurse at \_\_\_\_\_
- Call 911 for transport to \_\_\_\_\_
- Notify parent or emergency contact
- Notify doctor
- Administer emergency medications as indicated below
- Other \_\_\_\_\_

**A Seizure is generally considered an Emergency when:**

- ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- ✓ Student has repeated seizures without regaining consciousness
- ✓ Student has a first time seizure
- ✓ Student is injured or has diabetes
- ✓ Student has breathing difficulties
- ✓ Student has a seizure in water

**TREATMENT PROTOCOL DURING SCHOOL HOURS: (include daily and emergency medications)**

Daily Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

**Emergency/Rescue Medication:** \_\_\_\_\_

Does student have a **Vagus Nerve Stimulator (VNS)**? YES NO  
 If YES, Describe magnet use \_\_\_\_\_

**SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS:** *(regarding school activities, sports, trips, etc.)* \_\_\_\_\_  
 \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_